

Sterling Retiree Rx Prior Authorization Form

MYOZYME

Coverage Criteria / Required Medical Information

Diagnosis confirmed by an enzymatic assay showing a deficiency in acid alpha glucosidase or DNA testing.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

MYOZYME	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			

Comments

--

Physician Signature: _____

Fax Form to 1-866-481-3704